

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER **-62-017443**

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **317** Primary Registration District No. **544** Registrar's No. **1188**

FILED APR 27 1962

VS 300
Rev. 4/59

14003

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkwood c. FULL NAME OF (If NOT in hospital, give location)* HOSPITAL OR INSTITUTION St. Joseph's Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jefferson c. CITY OR TOWN High Ridge Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Rt 1, Box 546 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNE Middle O. Last ALDRIDGE		4. DATE OF DEATH Month April Day 16 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-15-1900
9. AGE (last birthday) 61		10. IF UNDER 1 YEAR Months 61 Days 16 Hours 10 Min. 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Nurse		10b. KIND OF BUSINESS OR INDUSTRY Practical Nursing	
11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Henry Holdenried		13b. MOTHER'S MAIDEN NAME Dora Jost	
14. NAME OF HUSBAND OR WIFE William Aldridge		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT William Aldridge, Address above	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Failure DUE TO (b) Cerebral Thrombosis DUE TO (c) Atherosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 10 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 9:30 a.m. 8 p.m. 8 Month, Day, Year 4/16/62	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION House Springs, Mo. COUNTY Jefferson STATE Missouri	
21. I attended the deceased from 4/16/62 to 4/16/62 and last saw her him alive on 4/16/62 Death occurred at 9:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Jaya Kilpatrick DO DO	
22b. ADDRESS House Springs, Mo.		22c. DATE SIGNED 4-17-62	
23a. BURIAL, CREMATION, OR OTHER DISPOSAL BURIAL	23b. DATE 4-19-62	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
24. FUNERAL DIRECTOR JAY B. SMITH, Maplewood, Mo.		25. DATE RECD. BY LOCAL REG. 4-17-62	
26. REGISTRAR'S SIGNATURE James B. Murphy M.D.			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

Jay A Kilpatric DO
House Springs Mo

Essex 5-3515

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4029

P. O. Address Maplewood

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.